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*With Compliments of the Author.*

The Technique of Total  
Extirpation of the Fibromatous  
Uterus

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## THE TECHNIQUE OF TOTAL, EXTIRPATION OF THE FIBROMATOUS UTERUS.<sup>1</sup>

THE minority of all cases of fibroma or myoma of the uterus calls for any treatment, either medical or surgical.

When treatment is called for the author believes surgery is invariably to be preferred to any and every other method of therapeusis. This statement, of course, is based on the assumption that whatever method of treatment, medical or surgical, be decided upon will be carried out by those most competent in that special method.

Small submucous fibromata that can be safely removed through the cervix and vagina are best dealt with in that way, provided that the entire disease can be thus eradicated. This latter proviso will obtain, however, in only very exceptional instances as compared with the total number of fibromata demanding operative interference.

Salpingo-oöphorectomy, celio-myomectomy, and celio-hysterectomy are the other surgical resources, in the rising scale, at our command. Each has its proper indications and place. To enter upon a discussion of these indications is not the purpose of this paper. In relation to the two former—removal of the ovaries and tubes, and enucleation of the tumor or tumors with added salpingo-oöphorectomy—the author merely wishes to state that his results obtained from these methods have been sufficiently satisfactory to warrant him in the continuance of their employment in properly selected cases of fibroma and myoma of the uterus.

<sup>1</sup> Read before the Section on Gynecology and Abdominal Surgery, Pan-American Medical Congress, Washington, September 7th, 1893.



When hysterectomy is the only alternative left, total extirpation of the uterus has always appealed with stronger force to the writer's ideas of surgery than amputation through the cervix, no matter which of the many methods now in vogue of disposal of the resultant stump, either extra or intraperitoneal, be resorted to. So strongly has this conviction swayed the author's practice that he has absolutely no experience with the treatment of the stump in abdominal hysterectomy, all of his cases of hysterectomy having ended in total extirpation of the uterus.

Just here I may be permitted to allude to the misuse of the term hysterectomy—an abuse sanctioned by long usage.

Hysterectomy means literally cutting out the uterus, and there is nothing in the term which would justify a rational application of it to supravaginal amputation. The term hysterectomy having been thus (mis)appropriated to denote supravaginal amputation, I have been in the habit, for some years past, of using the tautological term "panhysterectomy" when speaking of total extirpation of the uterus. While this expedient was perhaps excusable in view of the circumstances and in the transition period of the development of the subject, the time has now arrived when, in the interests of clearness and a correct nomenclature, the term hysterectomy should be reserved to apply to total extirpation of the uterus; celio-hysterectomy and colpo-hysterectomy to denote respectively extirpation *via* the abdomen or *via* the vagina.

The author is convinced that the adherents of hysterectomy, as compared with supravaginal amputation, would increase in number were it not that total extirpation is generally regarded as the more dangerous operation. That it is not more dangerous, and quite possibly even less dangerous, in competent hands, larger statistics may, from present indications, soon be expected to show. That total extirpation is a more difficult operation the writer also believes to be an opinion based upon prejudice and want of familiarity with the procedure. The main object of this communication is to detail a technique of total extirpation of the fibromatous uterus which, albeit in a limited experience, has proven entirely satisfactory to the writer, and without further delay I will address myself to my subject.

The patient is placed in the lithotomy position and the vagina thoroughly disinfected in the usual way. The cavity of the uterus is disinfected, as far as possible in each individual case, by means of superficial curettage and irrigation with 1:2000 sublimate solution. The uterine cavity is packed moderately

with antiseptic gauze, usually 1 : 1000 sublimate. The vagina is next packed tightly with 1 : 1000 sublimate gauze and the patient changed to the Trendelenberg posture. The abdomen is opened above the pubis by an incision just large enough to permit the delivery of the entire tumor.

If the ovaries and tubes are found healthy, or at least not containing pathological secretions the escape of which would threaten infection of the peritoneum, and the uterine tumor not too large, extending but little, if any, above the umbilicus, and not weighing above four kilogrammes, the entire uterus, with the tumor or tumors, tubes and ovaries, is removed in one piece after the following method :

The tumor is delivered through the abdominal incision and pulled as far as possible out of the pelvis. A transverse incision is made through the peritoneum covering the anterior surface of the uterus from one broad ligament across to the other. This incision runs about three centimetres above and parallel to the reflection of the peritoneum from the uterus on to the bladder. The point of reflection is plainly indicated by a white, fibrous-looking transverse line. A similar transverse incision is carried through the peritoneum on the posterior surface of the uterus. The two peritoneal flaps thus marked out should be large enough to easily cover the defect in the pelvic floor left after removal of the uterus.

The peritoneal flaps are next stripped from the surface of the uterus. In doing this the bladder and ureters are carried forward with the anterior flap well out of the way of harm during the further steps of the operation.

The next step is the ligation of the uterine artery on either side. The arteries are secured by a subperitoneal mass ligature of stout catgut, carried well down to, but not into, the vagina. The distention of the vagina by the gauze packing makes this an easy matter, a point for counter-pressure being afforded by the gauze. In passing the ligatures in this, as well as in all other operations upon the broad ligaments, I prefer the excellent and most convenient ligature carrier devised by Dr. Clement Cleveland to all other instruments.

The broad ligaments are tied off by two further catgut ligatures on either side, one embracing the round ligament and the other the infundibulo-pelvic ligament and spermatic artery. The cutting-out of the uterus, tumor, and appendages in one piece between the ligatures is now an easy and bloodless procedure.



If the mass ligature of the uterine arteries has been correctly applied no bleeding will result, even from the divided vaginal arteries. The six ligatures are cut short and the knots turned downward toward the vagina in the next step of the operation—the closing of the gap in the pelvic floor.

This is effected by uniting the anterior and posterior peritoneal flaps by a transverse, running Lembert suture of catgut extending from the stump of one infundibulo-pelvic ligament across to that of the other, securely shutting off the peritoneal cavity from the vagina.

The peritoneum is dry-cleansed with sterilized gauze, the abdominal wound closed without drainage, and the patient returned to the lithotomy position. The gauze packing is removed from the vagina and replaced by a loose dressing of gauze applied in such a manner as to drain the supravaginal subperitoneal space. The patient is now ready for bed.

Modifications of the above plan are called for by certain conditions. Thus, if the ovaries or tubes present evidences or suspicion of containing infectious material, they should be tied off and removed the first thing after opening the abdomen. If the tumor extend above the umbilicus weighing more than about four kilogrammes, pass a rubber ligature around the cervical part, after stripping back the peritoneal flaps, amputate the bulk of the tumor, cauterize the cervical canal with the Paquelin or a tablet of corrosive sublimate, and remove the cervix in the manner described above. If multiple or intraligamentous fibromata fill the pelvis, make room by enucleating the fibroma or fibromata most in the way, and proceed as above.

The technique of total extirpation of the uterus above advocated is believed to possess the following advantages:

1. The danger of infection from the uterus or vagina is entirely avoided, or at least minimized. The cleansing of the vagina and uterus, and packing the latter with gauze, is a measure of precaution against infection which I take previous to all celiotomies, for whatever cause, in which there is a possibility that the uterine cavity may be opened from the abdominal side during the operation. In operating for the removal of fibromata the uterine cavity may be opened in the enucleation of a tumor or in amputation of the bulk of the tumor, and it may make the difference between life and death to find it in an aseptic condition.

2. The uterine arteries are secured with ease and certainty. The distention of the vagina by the gauze packing enables us to

carry the mass ligature well down to the vagina and to include the supply to the upper end of the vagina as well, so that there will be no bleeding of the vaginal arteries after cutting out the uterus.

3. The operation is practically bloodless. With the exception of the incision through the peritoneum fore and aft, no part is divided until its blood supply has been secured.

4. The danger of wounding the bladder or ureters is reduced to a minimum. These organs are lifted with the anterior peritoneal flap well out of the field of operation.

5. The closure of the peritoneum is as perfect as it can be made, its *status quo ante* is restored; and no foreign body is left in its cavity.

6. The after-treatment required is practically *nil*. My patients have generally left bed at the end of two, and hospital at the end of three weeks.

The author has performed total extirpation of the uterus for fibromata but six times, the last four cases being operated upon after the above-described method. All of the six patients recovered from the operation, though one died a sudden death some time afterward as a result of degenerative changes of the muscles of the heart antedating operation. The time required for the first of the four operations performed as described in this paper was one and a half hours. The last three were performed in or within an hour, the time being reckoned from the beginning of disinfection of the vaginal tract until the patient was ready for bed, and including the curettage of the uterus, the cleansing of the abdominal walls and two changes of position, from the lithotomy to the Trendelenburg and back. None of the tumors, however, was exceptionally large. They varied from fifteen to twenty-four centimetres in average diameter, and between three and a half and five and a quarter pounds in weight. The smallest reached to within three centimeters of the umbilicus, and the largest extended to some five centimetres above the navel.

It is with extreme diffidence I present this paper based, as it is, upon such a limited experience, before such a body of representative men, many of whom number operations of this character by the score. It is in the hope of eliciting a discussion, from which we may all derive benefit, that it is hazarded.



